



# Same-Day Surgery®

Covering Hospitals, Surgery Centers, and Offices for More than 35 Years

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## In an emergency, could you evacuate everyone? Learn from 3 ASCs that did

*Bomb threat, vapors in the AC system, and fire alarm meant clear out now*

By Joy Daughtery Dickinson, Executive Editor

On the surface, evacuating a facility might seem like a simple and straightforward process, but have you ever thought through exactly how you would evacuate patients, some of whom might be in surgery, as well as staff and families? Although such a scenario might seem far-fetched, consider these three recent examples:

- A disgruntled relative of a former patient called in a bomb threat to an ambulatory surgery center (ASC) in Eureka, CA, at 8 a.m. Aug. 8, 2011, and said a bomb would detonate at 11 a.m. Fifteen people had to be evacuated, including one from an operation in progress.
- On Sept 7, 2011, a roofing contractor was working with a cleaning solvent at an outpatient surgery facility in Stockton, CA, and vapors entered the building. A few dozen patients and staff members were evacuated, and one person with respiratory problems was taken to a hospital.
- At a surgery center in Jackson, MI, a fire alarm went off at 1:13 p.m. Nov. 8, 2011. About 20 people, including three patients, were evacuated from the building. Learn from their experiences:

When an anonymous man called in two threats that bombs would explode in about three hours at St. Joseph Hospital's Surgery Center in Eureka, CA, one surgery was in progress, according to the hospital.<sup>1</sup>

"We informed the surgeons and staff on the case of the bomb threat," says **Sherie Henderson-Bialous**, regional director of facilities-safety/security officer for St. Joseph Hospital, Eureka, and Redwood Memorial Hospital, Fortuna, CA. "They were willing to stay until the patient's case was complete. The patient was then transported via ambulance to St. Joseph Hospital for recovery." Two other patients scheduled to have surgery later were told to go to the hospital for their surgery.

Waiting patients were told to leave due to a security issue. A building maintenance supervisor informed police when he found a suspicious package outside the building, near some bushes. Traffic was closed for two hours.

The bomb squad examined the box and searched the building. The box was

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X-rayed and found empty. To be certain, the bomb squad used a robot to inspect the box and confirmed it was empty. The building was cleared for re-entry after about two and one-half hours. Because of the threat, the surgery center and hospital heightened their security procedures and didn't allow visitors to enter either facility with personal items on that day.

One lesson learned: Have a designated person you can radio or call to take down timelines, Henderson-Bialous says. "This was crucial due to the fact that this is a reportable event to the California Department of

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Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).

Production Editor: **Kristen Ramsey**.

Senior Vice President/Group Publisher: **Donald R. Johnston**.

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## EXECUTIVE SUMMARY

Three recent evacuations of ambulatory surgery centers (ASCs) offer lessons in how your program can prepare for such an event.

- Hold quarterly drills, and walk through the entire process.
- Make arrangements with a nearby facility to house evacuated staff and, if needed, patients. Ensure evacuated patients are covered to protect their privacy.
- If you are required to report timelines, have a designated person you can radio or call to record that information.
- Consider having cameras installed that are aimed at the outside of your building to record any suspicious activity.

Public Health," she says.

Another lesson was that it would be helpful to have cameras aimed at the building's exterior, Henderson-Bialous says. "This would allow you to see if a suspicious package outside was left by a staff member or someone else," she says.

Also, be aware that if you have a bomb threat, your staff probably will be asked to search the building. "As pointed out by the bomb squad, they would know what was supposed to be in the facility or not," Henderson-Bialous says. "Make sure when you hold a bomb threat drill to include this detail in the scenario."

## Vapors came in, staff & patients cleared out

In another 2011 evacuation, vapors from a cleaning solvent named Sarnasoly, used to remove glue, entered the central air system at the outpatient surgery facility of the Stockton (CA) Medical Offices of the Kaiser Permanente Central Valley Area.<sup>2</sup> A published report said roofing crews had been instructed not to use that solvent during the facility's business hours.<sup>2</sup>

"We had a roofing contractor doing maintenance work on our roof that day, and vapors entered the system after one of the roofing contractor's employees made an inadvertent error," says **Melanie Hatchel**, public affairs director at Kaiser Permanente Central Valley Area. "As soon as we learned of the problem, we took immediate action to prevent additional vapors from entering the ventilation system, stopped procedures in the surgery center, evacuated the building, and thoroughly cleared the air inside. We also contacted the Stockton Fire Department."

All Kaiser Permanente facilities have evacuation maps and procedures, Hatchel says. "We perform evacuation drills frequently to reinforce the practice, and this event demonstrated that the procedure worked quickly and smoothly," she says.

Persons who were evacuated waited in a lobby. One employee who complained of respiratory symptoms was treated and released, Hatchel says. By late morning, the fire department had cleared the facility, and scheduled surgeries were resumed, she says.

“We conducted a thorough review of the incident and used the information to strengthen our processes in place to identify and respond to any conditions that may be unique to a particular project, and to reinforce contractors’ training of their employees,” Hatchel says. She declined to provide more details. (*For information on an evacuation in response to a fire alarm, see story, below. For information on hostage drills and others that included evacuations, see story, p. 84.*)

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1. Greenson T. Bomb threat leads to evacuation of surgery center; hoax under investigation, FBI involved. The Times-Standard, Aug. 9, 2011. Accessed at <http://bit.ly/LbjVEu>.
2. Daly T. Stockton Kaiser facility exposed to solvent spill. News10/KXTV, Sept. 7, 2011. Accessed at <http://on.news10.net/nUjrje>.

## RESOURCE

To view an audiotape with photos demonstrating how an evacuation plan was tested at OA Centers for Orthopaedics in Portland, ME, go to <http://bit.ly/A5bdMF>. ■

# Fire alarm led to center evacuation

A fire alarm went off at Allegiance Health Surgery Center in Jackson, MI, in November 2011 that caused the evacuation of about 20 people, including three patients, from the building.<sup>1</sup> However, a fire wasn’t to blame.

A faulty sensor on a fire detector in the decontamination room caused the excitement. The building was cleared for staff and patients to return within 15 minutes.

When the alarm went off, two patients were in recovery, and one had just been taken back to the OR but still was awake, according to **Kay Morgan**, RN, nurse manager at Allegiance Surgery Center. “When the alarm went off, we didn’t know if it was a fire or not,” Morgan said. The center’s policy is to evacuate when the alarm goes off, regardless of whether a fire is seen or smelled.

The center performs quarterly fire drills, so staff members knew just what to do. The center has an agreement with a doctor’s office across the street to

use their facility and grounds in the event of an evacuation. Two patients who were in phase 2 postop were sitting in recliners with wheels, so nurses rolled them across the street. “We made sure they were covered so their privacy was protected,” Morgan says.

The patient who was on a surgery cart was wheeled into the doctor’s office. Staff then ensured everyone was out of the surgery center. Once that building was cleared by the fire department, staff had to tear down the OR setup and start again, since they didn’t know if anyone had been in the room during the evacuation.

The process went smoothly, because when the center holds quarterly fire drills, they don’t merely talk through the exercise, but they actually walk through the drill.

“Everyone did exactly what they were supposed to do,” Morgan says. “It couldn’t have gone smoother.”

Afterward, Morgan sent flowers to the patients because they had been inconvenienced, and she wanted to know they were appreciated. “They all called back and said that wasn’t necessary, and they mentioned how safe they felt,” she says.

To have the most effective evacuation:

- **Keep a list at the front desk of everyone in the facility.**

This list should include staff, physicians, sales representatives, patients, and visitors, says **Mark Mayo**, executive director, ASC Association of Illinois, and director of ambulatory services, Ambulatory Surgical Care Facility, Aurora, IL. This list will allow you to conduct a head count when you reach the relocation site, Mayo says.

“Otherwise fire officials may have to risk firefighters’ lives to conduct a search for missing persons,” he says.

- **Designate one person to lead the evacuation.**

One person should be designated to lead everyone to the relocation site, Mayo says. “Family may not know where to go to get safely out of the building,” he points out.

Once everyone is safe, one person needs to conduct a sweep of the building to see that each area is evacuated, he says. (*For more information on evacuations, see these stories in the April 2007 issue of Same-Day Surgery: “Georgia hospital hit by F3 tornado — post-op patients, others evacuated,” p. 41, and “What will you do if disaster hits your ORs? SDS programs share lessons from quake, tornado,” p. 44. To see how a surgery center assisted a tornado-hit hospital with evacuations, see “After Joplin tornado, center gives quick aid,” August 2011 SDS, p. 81.*)

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1. McMann A. Faulty smoke detector causes evacuation of Allegiance Health surgery center. MLive.com, Nov. 9, 2011. Accessed at <http://bit.ly/vuKB95>. ■

## Drills with ‘gunmen’ prepare ASC staff

To say members of the staff at this surgery center were busy on Feb. 18 of this year is a vast understatement. In one day, they confronted a gunman taking hostages, another who came in to steal drugs, and also a disgruntled employee with a weapon. Luckily for them, these situations were simply drills to test their disaster response capabilities.

The drills were held at the McAlester Ambulatory Surgery Center (MASC) of the McAlester (OK) Regional Health Center. Staff worked with the local police department and fire department, and each group selected one scenario to drill, says **John Johnson**, RN, director of the ASC. The ASC was only the fourth medical facility in the state to perform that type of drill involving multiple scenarios with the police and fire department, Johnson says.

Each code situation — bomb threat, fire, earthquake, etc. — has its own special requirements, says **Mark Mayo**, executive director, ASC Association of Illinois, and director of ambulatory services, Ambulatory Surgical Care Facility, Aurora, IL. “That is why it is important to vary the drill scenario to make sure that potential situations are practiced, etc.,” Mayo says.

In the scenario selected by the MASC, a man entered the facility with a plastic gun, pretended to shoot people as he went from room to room, and then held “hostages” inside a barricaded OR. Firecrackers added to the realism of the drill. Police brought in members of the SWAT team, who negotiated release of the hostages.

The staff learned to evacuate as quickly as possible, Johnson says. “In unaffected areas, you have to get everyone out of the building,” he says. Another lesson was that if someone is hurt, you don’t run in to save that person, because you might become a casualty, Johnson says. “We’re inclined to want to help people and not think about ourselves,” he says.

In another drill, a person tried to rob the center of narcotics, used a plastic gun to “shoot” people, and took “hostages.” As in all the scenarios, the fire department responded to triage those who were hurt. ASC staff assisted with the triage. “Those are good skills to do every few years,” Johnson said.

In this scenario, members of the SWAT team negoti-

ated the release of the hostages, then “shot” the armed robber after he released the hostages and began “shooting” at the SWAT team.

The lesson in this drill was that if someone is trying to steal drugs, give them to the person, Johnson says. “Don’t keep anything,” he says. “Follow all their commands.” Otherwise the situation can become more violent, Johnson says.

## What do you do with a violent employee?

In the final scenario, a disgruntled employee came in the back door, starting “killing” people, and took “hostages.”

Staff learned they needed to barricade themselves by locking doors and ducking behind large, heavy items, such as operating beds. They learned to not open a door, even if someone identified himself as a police officer, without confirming who was there, says **Lee Rogers**, charge nurse of the postoperative care unit and education/event coordinator at the MASC. Staff members would crack open the door only far enough to see the person before they let him in, Rogers says.

For those who could get away, employees learned to quickly create distance between themselves and the person shooting, Johnson says. “Take visitors and everyone else with you,” he says.

One important lesson learned in the drill was that the electrical wiring in the ceiling interfered with communication among members of the SWAT team, who used headsets. Eventually the team turned to other channels and communication methods.

One of the biggest lessons? Be alert to what can happen, particularly if you work in a geographic area where there is substantial drug abuse, Rogers says. “The biggest thing we learned is that you have to protect the patient, but you also have to protect yourself.”

Such events aren’t an everyday occurrence for ASC staff, Johnson says, “but every day you hear about someone shooting somebody.” ■

## Outpatient surgery patients at risk for blood clots

A study by the University of Michigan (U-M) Health System in Ann Arbor showed 1 in 84 highest-risk patients suffers a dangerous blood clot after surgery. Hospitalized patients often are warned of the possibility of venous thromboembolism (VTE). However these warnings have not necessarily been extended to the outpatient surgery population, says U-M surgeon and

lead study author **Christopher J. Pannucci, MD**, a resident in the U-M Section of Plastic Surgery.

With more than 60% of procedures now being done in the outpatient setting, the U-M study revealed a need for better patient screening of the large and growing group of patients having outpatient surgery.

“Once a setting for those having simple procedures, outpatient surgery now includes a greater variety of procedures from plastic surgery to cancer operations and orthopedic surgery, and not all patients are young, healthy individuals,” says Pannucci.

Previous research shows that despite an increase in the presence of VTE risk factors among patients such as advanced age and obesity, fewer than 50% of outpatient centers have VTE prevention guidelines, and even fewer adhere to them. The National Quality Forum (NQF) board of directors has just endorsed 14 patient safety measures, including VTE patients with anticoagulant overlap therapy and intensive care unit VTE prophylaxis.

The U-M study published online ahead of print in *Annals of Surgery* provides a view of what drives an increased risk for VTE in the changing outpatient surgery environment. Researchers evaluated more than 200,000 outpatient surgeries at centers across the country included in the American College of Surgeons’ National Surgical Quality Improvement Program Participant Use File.

Vein surgery and arthroscopic surgery are important drivers of VTE risk, which is well-known, but the U-M analysis showed that most patients had multiple factors that could put them at risk for blood clots. Age, surgery length, current pregnancy, active cancer, and type of surgical procedure were all indicators of VTE risk. With the information, the researchers created and validated a risk-stratification tool that can be used to predict a patient’s risk for VTE. The tool identified a 20-fold variation in VTE risk from 0.04% to 1.12% among the outpatient surgery population.

“These data are in stark contrast to provider and patient expectations that outpatient surgery is a low-risk event,” Pannucci says. “It also underscores the importance of evaluating a patient’s individual risk factors as opposed to procedure type alone.”

The risk model identified by the U-M might improve the informed consent process for outpatient surgery patients by providing clear, data-driven information to patients about their risk for developing VTE, authors say. Prevention of VTE is considered a major patient safety issue and indicator of quality care by the U.S. surgeon general. As a result, hospitals, including the U-M Health System, have developed robust VTE prevention guidelines for patients. *(To access an abstract of the study, go to <http://bit.ly/JDDv8O>.)* ■

## Auto industry techniques boost OR morale, teamwork

For a year and a half, the University of Michigan (U-M) Health System in Ann Arbor turned one of its head and neck surgery practices into a laboratory. The goal: to see if “lean thinking” techniques pioneered by the auto industry could be applied to the operating room in ways that simultaneously improved service for patients as well as improve overall efficiency. The answer was a resounding, “Yes.”

Turnaround time between surgeries fell by more than 20%, while measurements of morale, teamwork, and effective problem-solving rose. The number of cases finishing after 5 p.m., requiring costly overtime, was cut in half.

“The efficiencies should not only enable us to reduce waiting times for patients scheduled to have elective procedures, but our results showed staff from scrub nurses to anesthesiologists are more empowered and teamwork has risen to new heights,” says surgeon **Carol Bradford, MD**, chair of U-M’s Department of Otolaryngology and the study’s senior author. “Extrapolating our results from one two-day-a-week surgical practice to U-M’s 35 operating rooms, we calculated that lean thinking might be able to create as many as 6,500 hours of new capacity to treat patients each year, which has the potential to provide cost savings from reducing waste and to generate new revenue.”

The lean study was the first of its kind to be implemented in an otolaryngology operating room at an academic health center. The findings are published in the June issue of the *Journal of the American College of Surgeons*. To access the abstract, go to <http://bit.ly/NpbOVe>.

Meanwhile, surgical residents reported the changes didn’t limit their training. Instead, the authors note, working in a lean environment provides an opportunity for them to carry experience with the practices to new institutions after their residency.

### How they did it

Representatives from each OR job mapped out their normal workflow, identified critical junctures, and worked to find root causes for valueless work, known as “muda” in the lean literature, an adaptation of a Japanese term.

Over a nine-month period, the researchers compiled data on OR turnover time, which they measured as the time between the departure of one patient and the

arrival of the next patient, and turnaround time, which they measured as the time between the final dressing on one patient and the first incision on the subsequent patient. This data provided a baseline by which to judge future changes.

Next came a three-month “observer effect period” during which staff members were made aware that their efficiency was being measured, but before any lean changes were made. This period allowed the researchers to determine whether monitoring alone would alter staff efficiency. Equipped with clipboards and stopwatches, the observers weren’t actually collecting data, but they were there to reinforce to OR employees that their performance was under scrutiny.

As it turned out, the observers had almost no impact. The mean baseline turnover time was 38.4 minutes. With the observers present, it was 38.3 minutes. Turnaround time rose slightly from 89.5 minutes to 92.5 minutes.

### The results? Significant improvement

After the lean changes were implemented, a significant improvement was seen in both measurements. Turnover time fell by nearly one-third to 29 minutes, while turnaround time dropped by 20% to 69 minutes.

Lead author **Ryan M. Collar, MD**, says, “What is really interesting and important is that the amount of time devoted to performing the actual surgery remained almost unchanged. The efficiencies we found were in other areas.” For example, Collar explains, staff identified a wasteful delay between prepping the OR for the next patient and transporting them there. “We found it made more sense to do preparation and transport at the same time, rather than waiting for one to be done before starting the other,” Collar says.

Similarly, the study found time could be saved by sending automated pages to janitorial staff when the dressing was being applied to a patient after surgery so that a cleaning crew would be available as soon as the patient left.

### Morale and education measurements

The researchers measured staff morale, their feelings of support and thoughts about problem solving, on a 5-point scale before and after the lean implementation. Progress was made in every category, with the composite score rising from 2.93 to 3.61, which is an improvement of more than 20%.

Co-author **John Billi, MD**, U-M associate vice president for medical affairs and U-M Medical School associate dean for clinical affairs, says, “This makes sense because lean thinking abandons top-down thinking

and emphasizes the perspectives of those closest to the work when rethinking and improving the workflow.”

There was no evidence that focusing on efficiency reduced the value of training for medical residents. Thirteen surgical residents were surveyed before and after lean implementation, and their scores remained virtually unchanged.

The authors note that surgical practices vary greatly and understanding the gains that might be realized by from broader implementation will require further study. ■

## Same-Day Surgery Manager



## Have staffing issues? Use common sense

By **Stephen W. Earnhart, MS**  
CEO  
Earnhart & Associates  
Houston, TX

**I**n nearly every business, the single largest expense and asset is people. Staff! Full time, part time, per diem, travelers — however you classify them, they are the largest line item on your budget, and often your largest headache.

Every company and industry with more than one person has staffing issues! Whether you are on staff at the local hospital or working in a surgery center, there are issues associated in how you interact with your peers, supervisors, and/or employees. Dealing with personalities, egos, demands, and shortness of. Also overstaffing, increasing, reducing, cutting back, hiring, firing, managing, tracking, laying off ... dealing with staff!

Adjectives describing staff members to me over the years are: demanding, frustrating, exhilarating, surly, committed, aggressive, passive, passive-aggressive, bipolar, asset, brutal, whiney, psycho, best, rude, worse, fun, dangerous, eager, timid, and, the best of them all, awesome! Staff is the reason we have managers, personnel departments, human resource professional, headhunters, attorneys, insomnia, and time-consuming details all focusing around individuals.

I want to share some of my experiences in dealing

with staffing from hundreds of clients over the years, be they hospitals or freestanding facilities. More than revenue or profits, staffing is the number one issue I hear about from surgeons, anesthesiologists, administrators, and staff. Fifty percent of the individuals at each location will tell me their problems stem from too little staff: “People here are over worked.” “They don’t get their breaks.” “We are going to lose them.” Etcetera. In the same hospital, I hear the other 50% telling me the opposite. “There are too many people here doing nothing.” “Members of the staff are falling over themselves.” “Why do we have so much staff?” Etcetera. It is 100% predictable.

So, what is the right answer? How much staff is too much, just enough, or too little? How do you measure it? How do you track your staff and with what? As surgical consultant, this is music to my ears. I can assure each of you that you are not the only one who has issues. We all do! I have it in my own company, and I should know what I’m doing!

Let me try to sum up staffing in requirements for every facility out there: common sense! Software tracking systems, scheduling tools, seminars, experts, and conferences will never replace using common sense to solve your staffing issues.

#### **Common sense advice for the manager:**

1. It is common knowledge to most that if you assign a task to a group of people, it will not be done as well as if you had assigned it to just one. The more people assigned to any task that we deal with in healthcare, the more they think it is someone else’s responsibility and the task will suffer. Never assign something to more than one.

2. People work better and harder if they know they are being watched. Watch! Walk around your environment. Ask questions of your staff. The old school term is “management by walking around.”

3. Be a leader. No one wants to work for someone who is wishy-washy. Make the difficult decisions. Stay with them unless it is shown that it is the wrong decision, and then have the courage to adjust the first decision. We all make many decisions in management. The more decisions we make, the higher the risk for making wrong ones. When it happens, admit it, adjust, and move on.

4. Socialize with people who are outside of the workplace. You might consider yourself to be the exception, but a well-liked supervisor or manager is ineffective. You want to have your staff’s respect, not friendship.

5. Stop using Facebook. Your staff saw what you did on your vacation, and it was not pretty.

#### **Common sense advice for the staff:**

1. Working for a paycheck is a terrible way to

make a living. If you can change your outlook on your job to the point that you like it, it will be much more rewarding for you.

2. Never accept a task from your manager that you do not understand. Ask until you understand what is expected of you. If you have to ask too many times on common sense issues, then you probably need to get another job that is easier to understand.

3. Never get involved in office politics if you can avoid it. It is not like a gang where you will lose a finger if you don’t join. Rise above the petty stuff.

4. Never hang around anywhere in the facility! If you are not busy or have finished everything that you need to do, hide!

5. Stop using Facebook. It hurts more people than it helps in the workplace. Take my word for it: Your supervisor sees everything you write! Get a paper diary with the little key lock, and put it under your bed instead.

6. Practice smiling in front of a mirror. Keep practicing until it doesn’t look fake. It really does make a difference at work. [Editor’s note: Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates new address is 238 S. Egret Bay Blvd., Suite 285, Houston, TX 77573-2682. Phone: (512) 297.7575. Fax: (512) 233.2979. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.] ■

## **Surgeons: CMS survey won’t lower SSI rates**

*More minimally invasive procedures needed*

A memo to the Centers for Medicare & Medicaid Services (CMS) from two leading surgeons on the literal cutting edge of infection prevention in the OR: Hospitals and federal regulators should encourage the use of newer and safer types of surgery and more transparency with patients on procedure options and possible outcomes. That step would do more to reduce surgical site infection (SSI) rates than inspections by CMS and other government regulators, they maintain.

“My prediction is that most hospitals will be found compliant with these measures that CMS is going to check, yet wide variations in surgical site infections will continue,” says **Martin A. Makary, MD, MPH**, an associate professor of surgery and health policy at the Johns Hopkins Hospital in Baltimore, MD. “Unfortunately, these metrics, while important, don’t capture the variation and complexity in care, and they

## Details of CMS Survey

A survey from the Centers for Medicare and Medicaid Services (CMS), which is in a pilot testing phase, advises inspectors to assess essential infection control measures in the surgical area, including:

- Healthcare personnel perform a surgical scrub before donning sterile gloves for surgical procedures (in OR) using an antimicrobial surgical scrub or an FDA-approved alcohol-based antiseptic surgical hand rub.
- Surgical masks are worn (and properly tied, fully covering mouth and nose) by all personnel in restricted areas where open sterile supplies or scrubbed persons are located.
- Traffic in and out of OR is kept to minimum and limited to essential staff.
- Cleaners and EPA-registered disinfectants, when in use, are labeled, diluted according to manufacturer's instructions, and are dated.
- Anesthesia equipment is cleaned and disinfected between patients.
- All surfaces, including but not limited to floor, walls, and ceilings, have cleanable surfaces, are visibly clean, and there is evidence that all surfaces are cleaned regularly in accordance with hospital policies and procedures. ■

don't capture the variation in surgical practice.”

While conceding that much of its effort is to emphasize “the basics,” CMS has developed a draft hospital survey that includes a surgical procedure tracer to monitor infection control elements in the OR. (*See details of the survey, above.*) The proposed guidelines outline strategies that have been around for at least the last 10 years, says **Ramon Berguer**, MD, general surgeon at Contra Costa Regional Medical Center in Martinez, CA. “I can't say I was impressed at how far-reaching the CMS guidelines were,” he says after reviewing the survey for AHC Media, publisher of *Same-Day Surgery*. “I was not impressed they were pushing the envelope at all.”

Makary concurs, saying, “It doesn't push to any new ground like antibiotic sutures, skin closure devices, minimally invasive surgery. It's pretty much run-of-the-mill, and it won't make any difference in infection rates.”

Another omission in the CMS surveyor guidelines involves scalpel safety and sharps handling, though that may be beyond the agency's regulatory reach. “Sharps safety items have been considered to be out of the scope of Medicare,” Makary notes. The Occupational Safety and Health Administration (OSHA) generally takes responsibility for that area. While a rare risk to patients, sharps injuries exposed OR personnel to the risk of infection by HIV, viral hepatitis B and C, and bacterial infections in as many as 15% of operations, according to a 2007 report by the American College of Surgeons.<sup>1</sup>

ORs have considerable room for improvement in how they handle sharps safety, particularly with regard to newer recommended practices such as double gloving, blunt tip suture needles, and the hands-free technique, Berguer says.

While the CMS surgical procedure tracer standards are silent on sharps safety, they pay considerable attention to documentation compliance, he says. Any hospital with an infectious diseases nurse that complies with existing infection control standards will have no difficulty passing the CMS inspection, Berguer says.

One change CMS could make to achieve better outcomes involves requiring transparency and improved methods of informed consent, suggests Makary, author of a book in press for publication, “Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care.” Patients who are considering surgery need to be fully informed and educated about the most realistic benefits and risks they face and learn about all available options, including not having surgery at all, he says.

“In my career and training, I've seen unnecessary operations that result in infections,” Makary says. “Those preventable harms or infections are not at the level of hand washing or sterile technique; they're at the level of choice to do the procedure and informed consent that overstates benefits and understates risks.”

When health authorities quote infection and mortality rate statistics, they often use data that comes from some of the largest health centers, and these rates could be significantly lower than what patients might find at their own local hospital.

“We are doing a research study now and are finding providers at a hospital are not aware of their hospitals' infection or complication rates, so how can they be providing patients with accurate information?” Makary says. “This is the basis for a new movement: a shared decision-making movement.”

Shared decision-making would be possible only with transparency and publicly available data, such as having hospitals publish their local complication and

infection rates online, he adds. “What’s going to work better?” Makary says. “A regulation where you send in government inspectors to check the things most people are doing, or empowering consumers to go to hospitals where there is good information on their performance?”

Few hospitals will lead this effort without some government requirement or incentive, he adds. “Right now, the only things reported publicly are what Medicare is requiring, and that includes very few outcomes,” he says. “In fact, surgical site infections are one of the only outcomes that Medicare requires in public reporting, and that will start this summer.”

### Maximize minimal invasive surgery

Another change that Medicare has not promoted but which would make a huge difference in surgical infection rates is the move to minimally invasive surgery (MIS) whenever possible and clinically indicated, he adds.

“There’s a vast underutilization of minimally invasive surgery in the United States,” Makary says. “MIS is associated with infection rates of approximately 1%, which is remarkable.”

The overall surgical site infection rate in the United States is 1.9%, according to 2006-2008 data from the Centers for Disease Prevention and Control (CDC). However, this rate can range as high as 10% to 40% depending on the hospital and type of procedure, Makary says.

MIS incisions are small, which allows little space for infections to set in. Several studies have shown great results from the use of MIS, yet it’s underused because of culture, finances, lack of peer review, and understating options to patients, he says. MIS also results in decreased pain and shorter hospitalization rates, but patients are instead told they should have the traditional surgical procedure because that’s what many surgeons prefer, Makary says.

Health systems could improve their own surgical site infection rates by changing the culture to encourage MIS and by making several other changes, such as making it easier for doctors and staff to do the right thing, Berguer says. “Often you go into a hospital and they can’t get the surgeon to wear eye protection,” he says. “This is because the eye protection equipment is in a closet down the hall.”

The solution is to make it easier for doctors to pick up the gear by simply putting the equipment where they can more easily reach it. Another strategy would be to place video cameras next to the sinks so doctors are observed while washing their hands. This step has been shown to improve compliance and lengthen

the time spent washing hands, Makary suggests. One institution that installed cameras noticed dramatic improvements in hand washing rates, similar to a speed-trap camera at an intersection, he adds.

### REFERENCE

1. ST-58 – Statement on sharps safety. *Bullet Amer Col Surg* 2007;92(10): <http://bit.ly/L1fHzW>. ■

## CDC: Single-use vials are for one patient only

Drug shortages and lean economic times might tempt some to scavenge the remnants of doses left in a “single-dose” vial. After a series of hepatitis outbreaks over the last decade, leaders at the Centers for Disease Control and Prevention (CDC) are concerned. The agency recently restated its position on the use of single-dose/single-use vials and seeks “to dispel inaccuracies being disseminated to healthcare providers.”

The CDC concedes that shortages of some essential medications might warrant implementation of meticulously applied practice and quality standards to subdivide contents of single-dose/single-use vials, but this process must be done under rigorous standards for pharmaceutical compounding of sterile preparations. The CDC statement reads as follows:

The CDC guidelines call for medications labeled as “single dose” or “single use” to be used for only one patient. This practice protects patients from life-threatening infections that occur when medications get contaminated from unsafe use. Concerns have been raised about whether these guidelines and related policies contribute to drug shortages and increased medical costs to healthcare providers. CDC recognizes the problem of drug shortages; however, such shortages are a result of manufacturing, shipping, and other issues unrelated to the above guidelines. CDC’s priority is protecting patients from harm. CDC routinely investigates and is apprised of infectious disease outbreaks involving single-dose/single-use vials being used for multiple patients. These outbreaks cause extensive harm to patients, and they are associated with significant healthcare and legal expenses. Therefore, CDC continues to strongly support its current policies regarding single-dose/single-use vials. It is imperative that drug shortages and drug waste concerns are dealt with appropriately and do not lead to unsafe medical practices that impose increased disease risk on patients. (*At press time, Congress was close to passing*

the FDA Safety and Innovation Act, which addresses the drug shortage. For tips on surviving drug shortages, see package of stories in the April 2011 issue of Same-Day Surgery.) ■

## Recommendation issued to prevent needlesticks

The Food and Drug Administration, National Institute for Occupational Safety and Health (NIOSH), and Occupational Safety and Health Administration (OSHA) have recommended health-care professionals in surgical settings use blunt-tip needles when clinically appropriate to suture muscle and fibrous tissue to help prevent needlestick injuries, according to the American Hospital Association.

“Published studies show that using blunt-tip suture needles reduces the risk of needlestick injuries from suture needles by 69%,” the notice states. “Although blunt-tip suture needles currently cost some 70 cents more than their standard suture needle counterparts, the benefits of reducing the risk of serious and potentially fatal bloodborne infections for health care personnel support their use when clinically appropriate.” About one in four needlestick injuries occur in surgical settings. “Published literature indicates that while needlestick injury rates have been decreasing among non-surgical health care providers, this has not been the case among those who work in surgical settings,” the notice states.

To view the recommendations, go to <http://1.usa.gov/KUf3Ei>. ■

## New tool may mean 25% more collected

*Accuracy will be much greater*

Registrars at Sarasota (FL) Memorial Health Care System have gotten very good at calculating estimates of gross charges manually, but the department is implementing a price estimation tool to make the job much easier, says Diane C. Settle, CPA, CHFP, executive director of revenue cycle.

“I expect this will really make our numbers go up. I’m really hoping our next fiscal year is going to be awesome,” Settle says. “We will be able to show the deductible and the coinsurance in a written letter. It’s going to be much more formal.”

Performance bonuses for registrars will be based

on a 15% increase in collections, the same as for the previous five years, but Settle is hopeful that the tool might increase collections by up to 25%.

Staff members now have frequent conversations with the physician’s office staff about the actual procedures being done, and they consult with coders to be sure that the right code is used. “Some staff think we’ve gotten so good with manual processes that there isn’t much more opportunity out there, but I’m optimistic,” Settle says. “We’re currently collecting close to 2% of net revenue on an annualized basis.”

### More accuracy

With the new tool, registrars will be able to explain to patients exactly how an estimate was calculated.

“Right now, we can see the deductible through our eligibility system, but staff don’t necessarily know what the contracted rate is,” says Settle. If a patient with a \$5,000 deductible is having major surgery, the entire deductible will be collected, but if it’s a minor surgery, staff will estimate a lower amount to be sure they’re not overcharging the patient.

“We are estimating on the low side,” Settle says. “But if we ask for \$1,500 and the patient ends up owing \$2,200, we sometimes never get paid the remainder.” Estimates now will be closer to what the patient actually will owe, she says.

“Staff right now go to multiple payer websites and, even then, sometimes can’t find the answers they need,” she says. “We have a lot of patients who travel here from all over the country. If they have a smaller insurance plan, it’s a real challenge to determine what’s going to be owed.” ■

## 5 new surgical codes, effective July 1, 2012

Five new mid-year codes representing surgical services were added to the list of ambulatory surgery center (ASC) payable procedures, effective July 1, 2012, according to the ASC Association

The five new codes are as follows (code 0308T replaces code C9732, which was discontinued, effective June 30, 2012):

- 0302T: Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation when performed and intra-operative interrogation and programming when performed; complete system (includes device and electrode).

- 0303T: Insertion or removal and replacement

of intracardiac ischemia monitoring system including imaging supervision and interpretation when performed and intra-operative interrogation and programming when performed; electrode only.

- 0304T: Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation when performed and intra-operative interrogation and programming when performed; device only.

- 0307T: Removal of intracardiac ischemia monitoring device.

- 0308T: Insertion of ocular telescope prosthesis including removal of crystalline lens.

## New drug/biologic codes effective July 1

Six new drug/biologic codes were payable effective July 1, 2012. The six new drug/biologic codes are:

- C9368: Grafix core, per square centimeter.

- C9369: Grafix prime, per square centimeter.

- Q2045: Injection, human fibrinogen concentrate, 1 mg.

- Q2046: Injection, aflibercept, 1 mg.

- Q2048: Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg.

- Q2049: Injection, doxorubicin hydrochloride, liposomal, imported lipodox, 10 mg.

Drugs and biologics that have rates based on the preceding quarterly average sales price will have their rates updated, effective July 1, 2012. A copy of the transmittal from the Centers for Medicare & Medicaid Services (CMS) explaining the changes is available at <http://go.cms.gov/KwFJqN>. ■

## Surgeons and CDC form alliance to prevent SSIs

A joint, strategic partnership to improve surgical patient safety at the national level has been announced by leaders of the American College of Surgeons (ACS) and the Centers for Disease Control and Prevention (CDC). At the core of the alliance is combining expertise and organizational resources in tracking, reporting, and preventing surgical site infections (SSIs) and other adverse outcomes among surgical patients.

The ACS National Surgical Quality Improvement Program (ACS NSQIP) and the CDC's National Center for Emerging and Zoonotic Infectious Diseases, Division of Health Care Quality Promotion (DHQP), will form a working group to jointly develop and maintain measures of SSIs and infectious and noninfectious complications that affect surgical patients. The work group will build

upon the portfolio of SSI measures developed jointly by ACS and CDC in 2010 for abdominal hysterectomy and colon operations. These measures are now in place as part of Medicare quality reporting programs.

“Partnering with the CDC speaks to our shared commitment to surgical patient safety, preventing complications, and lowering costs,” said **David B. Hoyt, MD, FACS**, executive director of the American College of Surgeons.

A key objective of the new ACS-CDC collaboration is to harmonize and maintain the ACS NSQIP and CDC's National Healthcare Safety Network (NHSN) definitions, data requirements, and technical specifications to allow data transfers from ACS NSQIP to NHSN, yet still maintain the individuality of each reporting system. The ACS and CDC will explore ways to maximize the use of electronic health records (EHRs) for collecting and submitting standard SSI measure data and other data to aggregating systems, namely ACS NSQIP and CDC's NHSN.

**Clifford Y. Ko, MD, FACS**, director of the ACS Division of Research and Optimal Patient Care, which administers ACS NSQIP, said, “It's clear that our national health system is seeking better ways to measure quality care. Better data makes it possible because it creates more opportunities to improve the care hospitals and providers offer their patients. ■

### CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to [www.cmecity.com](http://www.cmecity.com) to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
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5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

### COMING IN FUTURE MONTHS

- Is there a problem if your vendor's background isn't probed?
- Newly approved patient safety measures
- Could robes and flowers increase your patient satisfaction?
- What constitutes a comprehensive H&P

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## CNE/CME OBJECTIVES

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

## CNE/CME QUESTIONS

1. What item should be included in your bomb threat drills, according to Sherie Henderson-Bialous, regional director of facilities-safety/security officer for St. Joseph Hospital, Eureka, and Redwood Memorial Hospital?  
A. Having police search the building.  
B. Having firefighters search the building.  
C. Having staff search the building, since they would recognize items that are not supposed to be in the facility.
2. What kind of agreement did Allegiance Health Surgery Center have in place that assisted its evacuation when a fire alarm went off and three patients had to be evacuated?  
A. The center had an agreement with the local hospital to send ambulances to pick up patients.  
B. The center has an agreement with a doctor's office across the street to use their facility and grounds.  
C. The center had an agreement with a nearby surgery center to transfer patients there.
3. What did the staff at McAlester Ambulatory Surgery Center learn during drills involving hostages, according to John Johnson, RN, director?  
A. If someone is hurt, you don't run in to save that person, because you might become a casualty.  
B. If someone is hurt, put something heavy between you and the gunfire before you run in to save that person.  
C. If someone is hurt, create a distraction before you run in to save that person.
4. At the University of Michigan Health System, one of its head and neck surgery practices reduced turnover time by nearly one-third and turnaround time by 20% by doing which of the following?  
A. Reduced the time of the actual surgery.  
B. Staff would prep the OR for the next patient and transporting the patient at the same time.  
C. Sent automated pages to janitorial staff when the dressing was being applied after surgery so that a cleaning crew would be available as soon as the patient left.  
D. B & C